

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-029712

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 304 Registrar's No. 166

FILED AUG 6 1962

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>Charleston</u>	
Length of stay in lb <u>1 Day</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Delta Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>311 So. Olive St</u>	
3. NAME OF DECEASED (Type or print) First <u>Madison</u> Middle <u>Miller</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/13/1906</u>
9. AGE (last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Holly Springs Miss. U.S.A.</u>	
11. BIRTHPLACE (City and state or country) <u>Holly Springs Miss. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Eddie Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Holt</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Mrs. Margie Ellison 308 S. Hoggie</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Heart Failure</u> DUE TO (c) <u>Atrial Fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>7</u> a.m. <u>31</u> Month <u>6</u> Day <u>2</u> Year <u>1962</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Charleston Mo.</u>	
20g. COUNTY <u>Mississippi</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>7-31-62</u> to <u>8-1-62</u> and last saw her alive on <u>8-1-62</u> Death occurred at <u>4:35</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Ande B. Smith MD</u>	
22b. ADDRESS <u>Sikeston Mo.</u>		22c. DATE SIGNED <u>8-2-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-6-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston Mo.</u>
24. FUNERAL DIRECTOR <u>David Funeral Home - Charleston</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 2-1962</u>	
ADDRESS <u>Charleston Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Janette Waldman</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DATE AMENDED

INSTEAD OF

USE BLACK INK

OR TYPEWRITER RIBBON

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Rev. 4/59

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AUG 17 1962  
AUG 14 1962

Permit signed Aug 1 - 1962

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Willie R. Davis

Licensed Embalmer No. 5129

P. O. Address Charleston S.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.